

by manipulation; and as it is well to fix the paternity of it on the proper person, I append it.

HANOVER, N. H., Feb. 4, 1858.

Dr. R., DEAR SIR: Yours of the 30th is received, and I have to thank you for the interest taken in the matter of dislocation. Dr. C. has stated the thing so, that I doubt the propriety of adding anything to his article at present. I would suggest that you may emphasize the fact that *I discovered this method as early as 1826*. My first patient was a little boy, the son of Mr. Francis Ayers, of Gilmanton, N. H. I had assistants for several hours, while I was trying extension by the "clove hitch." At last I resorted to the method which I now use and recommend in my lectures, with complete success. I came to Hanover, Sept. 15, 1838, and, in a few days after, one Sunday afternoon, at the Dartmouth Hotel, I accomplished the reduction on a patient of Prof. Reuben D. Mussey, by the name of Williams. I refer to Dr. Mussey, now of Cincinnati, to corroborate. The first published case was by Dr. Arnold Morgan, of Canaan, N. H., who was my pupil, and derived the information from me in a course of private instruction, and who was afterwards my assistant in business. In a great number of these cases that have occurred to me, I have never failed to effect the reduction in a single instance. I can, moreover, bring forward at this time several parties, on whom I have practised this operation, since I hit upon it, in 1826. It is a very simple matter, but of incalculable benefit to any unfortunate who happens to have this luxation.

With regard, I remain yours, &c.,

DIXIE CROSBY.

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#### DOMESTIC SUMMARY.

*Dislocation of both Thighs—one into the Foramen Ovale, the other on the Dorsum of the Ilium, with Fracture of the Cervix Femoris.*—Dr. J. MASON WARREN communicated to the Boston Society for Medical Improvement the following interesting case: The patient was brought into the Massachusetts General Hospital, having been crushed by the giving way of a wooden house, which he was engaged in moving, being struck upon the back as he was making the attempt to escape. The right leg first attracted attention. The thigh was fixed, slightly flexed on the body, standing off from it, the foot presenting nearly forward, the limb apparently elongated. A deep hollow was felt in the region of the trochanter, which had itself disappeared. The man being etherized, and the pulleys adjusted, a gradually increased force was applied to extend the limb. A sheet was now placed under the upper part of it, and an assistant, standing on the table, directed to lift the limb. A slight rotation was now made to disengage the head of the bone, and it went into its place without any perceptible noise or action of the muscles.

The right limb being replaced, it was now perceived that the left limb was distorted, and presented all the signs of a dislocation upon the dorsum ilii. It was firmly fixed, shortened, the toes everted and resting upon the upper part of the other foot. The trochanter was prominent, and drawn up from its place to within about three inches of the crest of the ilium. On making an effort to move the limb, an indistinct, but very decided crepitus was perceived.

The pulleys being adjusted, and a fresh dose of ether administered, the limb was slowly and with much difficulty drawn down, a slight rotatory motion being given to it when the head was on a level with the socket. It went into its place with a loud crack, which was heard by all the assistants. The limb now appeared, at first, to have regained its natural condition. As the effect of the ether upon the muscular system subsided, the limb gradually contracted, and the foot became slightly everted. An examination now being made, by rotating the limb, and placing the finger on the trochanter, it was perfectly evident to all present, that there was a comminuted fracture of the thigh-bone,

passing through the trochanter. The two limbs were therefore confined—the right one by a weight attached to it, and a cradle placed over it. To the left, Desault's splint, as used at the Hospital, was applied. In addition to the above injuries, there was a fracture of two or three ribs on the left side.

The best explanation of the appearances offered by the left limb is this. The violent crushing force dislocated the femur, at the same time breaking the neck of the bone. The separation of the parts was not, however, sufficient to prevent them from being replaced, but the fracture was made complete, on the bone being returned to its socket.

The subsequent history of this case is not without interest. The patient, from the time of his admission, had complained of his chest, where, it may be remembered, one or two ribs were broken. Suddenly, one night, great difficulty of breathing came on, and, upon examining the chest, it was discovered that a congestion of the posterior part of both lungs had taken place, such as has before been observed at the Hospital, in patients who for a long period of time have been confined on the back, without movement, after serious injuries to the lower limbs. From this affection he very gradually recovered.

At the end of two months, he left the Hospital well. The motion of the right limb was natural. The left leg was a little shortened. The motions of the hip-joint were limited; on examination, the trochanter was found irregular at the point of fracture. As it had been thought possible that the head of the femur might have been left on the dorsum of the ilium when the complete fracture of the limb took place, search was made for it, but it could not be found there.

In this connection, Dr. Warren mentioned the following case of dislocation, and which was interesting in a practical point of view. A man was brought into the Hospital with a dislocation on the dorsum ilii, which was caused by a wagon passing over him, the limb being at a right angle with the body. Ether was given, the pulleys applied, and the dislocation reduced. On raising the limb slightly, to examine it, it at once slipped out of place, and was reduced again with some difficulty. This experiment was once or twice repeated, with the same result. Dr. Townsend, who saw the man, verified the fact. Slight, though not very marked crepitus attended the movements of the joint. From fear of displacement, and with the idea of a fracture of the edge of the upper and back part of the cotyloid cavity, the limb of the patient was kept rigidly confined in Desault's apparatus, and his desire to return home resisted. The precautions taken in this case were afterward shown to be not without reason. About three weeks after the accident, Dr. W. being out of town, the patient got out of bed, and while resting on the injured limb, attempted to turn around, thus giving a slight twist to the hip-joint. The bone immediately slipped from its socket. This accident afterward, in the course of the next week, recurred a number of times from simple motions made by the patient while in bed. It was then determined to put on a permanent splint, and allow it to remain on for several months. This had the desired effect, and the patient was seen by Dr. W. some months after leaving the Hospital; the joint was then slowly regaining its mobility.—*Boston Med. and Surg. Journ.*, Jan. 14, 1858.

*A Simple and Efficient Bandage for Fracture of the Clavicle.*—Dr. JULIAN CHISOLM describes (*Charleston Medical Journal*, March, 1858) a simple, and what seems to be, at the same time, a very efficient bandage for fracture of the clavicle.

The bandage is formed of a strip of cloth from three to five feet long, and from eight to eighteen inches wide (according to the size of the patient) which is slit from both ends in such a way as to leave a bridge from one to two inches wide in the centre, connecting the two lateral half strips. A soft pad having been placed in the axilla, to act as a fulcrum upon the riding fragment, the affected arm is carried over the chest, the palm of the affected hand resting upon the side of the thorax, under the border of the opposite arm-pit. This position of the arm removes all deformity, and brings the fragments in apposition. The centre of the bridge of cloth is now placed under the elbow, the superior strip, which covers half the height of the affected arm, is made to en-

circle the chest; one end is carried forward, the other backward, to meet the opposite armpit, where, after enveloping the hand, and being firmly drawn upon the affected arm, they are secured with needle and thread, pins, or an ordinary knot. The inferior strap, which is placed under the affected arm as a sling, is made to traverse the chest in the same way, the ends meeting over the opposite shoulder, where they are secured by the same means. If at the several points where the strips cross each other, a stitch or a pin is placed, the result will be a firm casing, which, even in the most restless child, cannot be disarranged. The needle and thread is by far the preferable mode of completing and sustaining the adjustment, as the stitches are not apt to be interfered with by the patient or friends; pins, on the contrary, are often tampered with, particularly if there should be any restraint from the bandage. As the material is quite soft, no binding nor excoriations are produced. The bandage supports the entire limb in an easy position, and clasps the arm sufficiently to prevent injurious motion, without being irksome to the patient. It requires no constant renewal, as one single application, if carefully made and properly secured, can be worn until the cure is perfected.

Dr. C. says he has used this simple contrivance for several years with satisfaction.

*Some Remarks on Cataract.*—Dr. C. S. FENNER, of Memphis, Tenn., in a recent paper, under this caption (*North American Medico-Chirurg. Review*, Jan. 1858), makes the following remark in regard to the operation of couching, which, we think, for the credit of American ophthalmic surgeons, ought not to be allowed to pass without notice.

Dr. F. states: "When the cataract is hard, couching is the operation generally preferred by American surgeons, although by most English and German authors, it is placed in the lowest scale."

We feel quite sure that Dr. F. is mistaken in supposing that American Ophthalmic Surgeons differ from their brethren in England and Germany, in their estimate of the operation of couching; indeed, the very few in this country who practise or advocate that operation, constitute the exception, not the rule.

Mr. Dixon regards depression "as an unscientific and destructive operation," and the same opinion of it is expressed in the last American edition of *Lawrence's Treatise on Diseases of the Eye* (see p. 723). Mr. Walton and Dr. Mackenzie both hold similar views in regard to it (see *Ibid.*, p. 723 and 724).

Dr. Fenner, candidly admits, that his "own experience in displacement has not been so favourable as that reported by some American Operators."

And he goes on to state: "In my operations for cataract by displacement, I have often had to combat a subacute chronic internal inflammation, sometimes coming on several weeks after the operation, and seemingly induced by atmospheric influences. The presence of a hard lens in the vitreous humour in some instances causes irritation, followed by slight redness of the conjunctiva, inability to bear light, increased secretion of tears, a sensation of fulness in the eye, soreness to the touch, and pain at times extending to the terminal branches of the fifth pair of nerves. Iritis may supervene with effusion of lymph in the pupil, but generally the pupil remains clear, the vision gradually fails, until the eye becomes almost amaurotic. I have had this result to occur most frequently in delicate, aged females. Mr. Lawrence remarks that "internal inflammation commencing in the iris, and proceeding slowly, is a common occurrence after depression;" and Mr. Mackenzie, that "chronic inflammation of the internal textures of the eye is a frequent consequence of depression or re-clination. It is not attended by much pain, but prevents the eye from ever attaining a degree of healthiness sufficient to render it useful. The patient, perhaps, retains a considerable degree of recovered sight for some weeks after the operation; but epiphora, varicose dilatation of the external bloodvessels of the eye, and in general a contracted, but sometimes a dilated pupil supervening, the sight becomes weak, and in a few months is extinguished." I have repeatedly had cataract patients return to their homes able to see to read fine print with ease, yet in a few months scarcely able to walk about, and I have witnessed the same final termination in those who have been operated on by

experienced surgeons of the North and East; they returned home with good vision, but this gradually failed them, until they became amaurotic. Such being the occasional result, no case of cataract should be reported as cured, unless the state of vision is known six or twelve months after an operation; and if operators would keep their patients in view for that length of time, the final result of their operations, I am inclined to think, would not be so favorable as they sometimes report.

Every ophthalmic surgeon who has carefully watched the results of the operation of couching, has observed the same unfortunate consequences as those described by Dr. F., and this so very frequently, that couching has now few, if any advocates, anywhere among prudent and conscientious ophthalmic surgeons. Dr. F. is perfectly correct in his opinion, that no cataract should be reported as cured until the state of vision is known twelve months after the operation.

It is to the practice pursued by some surgeons, of hastily reporting their cases, before the ultimate result can be determined, that so much false glare has been thrown around operative surgery, and such erroneous estimates been made of the value of certain operative procedures, and which has in the present case, as we believe, misled Dr. Fenner.

*Thrombus of the Vagina.*—Dr. BOISLINIERE lately reported to the St. Louis Medical Society the following interesting case of this rare accident:—

The patient, a primipara of leucophlegmatic habits, with a normal pelvis, after an ordinary labour, ending with rather severe expulsive pains in the birth of a living child, was left comfortable, when, an hour and a half after, he was called to see her in haste. He found her in the greatest suffering, crying loudly and assuring those around her that this was ten times more severe than her labour pains. She complained then of a burning sensation in the vulva, and a severe bearing down on the rectum, which gave her a pressing inclination to go to stool. She suggested that it was piles. This pain was so agonizing that she had no words to express it. In fact, she could hardly utter two words in succession. This appeared to him the more strange from the great fortitude she had shown during her labour. Dr. Boisliniere confessed that he fell here into the same error committed by Dr. McBride in a similar case, and that he took this at first to be one of those violent tenesmic pains that are experienced sometimes after labour, when the child's head has quickly and violently swept over the vagino-rectal septum—a sort of severe spasm—and he ordered opium suppositories, and hot fomentations to the parts; the latter, as proved on trial, only aggravated the evil; the pain continuing to increase instead of abating. He made then a vaginal examination, which revealed to him the true nature of the complaint—it was a very large thrombus, beginning on the left side, ascending along the side of the pelvis as high up as the finger could reach, filling the whole of the vagina, so that the finger could with difficulty only be introduced, and descending as low down as the left labium, where it was characterized by great hardness and elasticity. This tumour was rapidly enlarging—he could ascertain this by keeping the end of his finger on its surface—the patient was in the greatest agony, her pulse was getting quick, her countenance anxious and distressed. There was only one course to follow—Dr. Boisliniere, under these circumstances, availing himself of the great experience of Dr. M. M. Pallen in matters of this sort, sent for him, and it was decided to open the tumour largely at once. Dr. Pallen then incised the tumour which was projecting and bluish—his incision extended to three inches in length and reached the cavity of this thrombus, after which he emptied it of the coagula it contained, except the most adherent at the bottom for fear of inducing hemorrhage, and a sponge was introduced in the vagina to act as tampon. The patient was immediately relieved and recovered well. The amount of clotted blood extracted must have been several ounces.

Dr. Pallen said, that the case related by Dr. Boisliniere was a very interesting one; interesting on account of its rareness, and on account of the fatality often attending them. He believed that the first published case in British midwifery, was that of Dr. McBride, which occurred in 1776. It had

however been observed before. Since then, it has been noticed and described by various writers. Dr. Denman saw three cases, and all recovering, he was induced to think that the disease was devoid of danger; subsequent experience has, however, shown that he was mistaken—death has frequently occurred.

This disease, which consists of an effusion of blood into the areolar tissue, may be in one or both labia, may extend into the pelvis, and into the perineum.

It doubtless, sometimes, occurs in the unimpregnated female; but it is usually an accompaniment of labour, appearing either during its progress, or soon after. The swelling of the labia, and the feeling of weight, are succeeded by great pain. If the distension be very great, the pain is agonizing; fever of an active kind ensues, and even delirium. The patient can only lie on her back, with her thighs widely separated. The tumour is of a livid colour, almost black, and is extremely tender.

Dr. Pallen added, that there could be no doubt that the effusion arose from rupture of some vessel. In a state of pregnancy, the vessels are in a varicose condition, and their rupture easily produces a large discharge of blood. What particular bloodvessel is ruptured, is not determined, probably the pudic vein.

"If the tumour," said Dr. P., "occurs before delivery, and increases slowly, and does not interfere with delivery, it might be trusted to nature. If it increase rapidly and interfere with labour, it ought to be laid open, and the coagula turned out. The same rules apply to the treatment, if it occur after delivery. If it be of slow formation, and not large, the application of cold cloths is all that is necessary; but if it form rapidly, and the pain is great, then we ought to cut it open, turn out the coagula, leaving those which are entangled in the areolar tissue, as they will tend to prevent further bleeding. This being done, the tampon should be used, to produce pressure on the blood-vessels.—*St. Louis Med. and Surg. Journal*, Sept., 1857.

*Fatal Asphyxia from Imperfect Combustion of Gas.*—The case of a gentleman found dead in his bath-room, and whose death was attributed to inhaling air rendered impure by a gas stove used to warm the room, was a short time since communicated to the Boston Society for Medical Improvement. The Society appointed a committee to investigate the circumstances, and in a recent report (*Boston Med. and Surg. Journal*, March 18, 1858) made to the Society, the committee express the opinion that an adequate and sufficient cause of the fatal result in this case is found in the deleterious products resulting from the imperfect combustion of coal gas.

The following account of an experiment upon a cat, placed in a room with one of the gas stoves, was read to the Society by Dr. Ellis:—

"The cat was placed in an iron grated cage, elevated two and a half feet from the floor, the room being eight feet square and ten feet high. The thermometer indicated 90° when taken out. The first thing noticed was a snapping of the eyes, then a crying (as is frequently heard in the night from cats), this becoming, in fifteen or twenty minutes, pretty loud. In a short time this crying stopped. The mouth moved, but without any noise. She sneezed fifteen or twenty times, and rubbed the nose and face with her paw; afterward tried to bite the iron grating of the cage. There was a flow of watery fluid from the mouth, but without any frothing. The mouth was open most of the time. While lying down she would try to get up on her back legs, and would fall over immediately. In thirty minutes there was a tremulousness and throwing back of the head. The respiration became long and stertorous. Convulsive movements came on about the epigastrium, which increased over the body generally, and in forty-eight minutes the animal was dead."

We trust that this very conclusive experiment will tend to awaken the profession and the public to the incalculable importance of free ventilation, and the employment of proper means for warming our houses; and that gas stoves, air-tight stoves, and many like economical means of warming—economical of the purse, at the expense of comfort, health, and duration of life—will be banished from our dwellings. Every means of warming which is not combined with ventilation—in which there is not a full supply of pure, atmospheric air, at not too high a temperature, combined with its entire and constant renewal—

is deleterious to living beings; it is productive of discomfort—sickness, and tends to shorten life.

The claims of the stomach for food are universally admitted, but those of the lungs for fresh air are almost as generally ignored, though the functions of the latter are no less essential to life and health than those of the former. Every human being requires eleven cubic feet of fresh air per hour for respiration, and, if this be not supplied, the blood becomes deteriorated, which is followed by an impairment of all the vital functions, and ultimately their cessation.

*Inverted Toe Nail treated without Operation.*—Dr. ROBERT CAMPBELL states (*Southern Med. and Surg. Journ.*, Feb., 1857) that, dissatisfied with the operation for evulsion of the nail, which he has long deemed, and very justly, we think, an unwarrantable measure of torture, he was led to devise some expedient which might answer the indication of *keeping the nail apart from the irritated flesh*. Whilst treating a severe case of inverted toe nail, in 1851, he tried an apparatus which gave him so much satisfaction, that he has adopted it in all cases since.

"This apparatus is formed of a bandage somewhat broader than the length of the nail—say  $\frac{3}{4}$ ths of an inch and  $\frac{1}{2}$  yard long, having a roll at one end about  $\frac{1}{4}$ th of an inch thick, to be used as a compress, to which the last turn of the bandage is tacked, to prevent the disposition, otherwise, to unroll on traction. This compress is applied in the groove, between the flesh (which is generally much enlarged) and the nail. The margin of the compress, at which the last turn of the bandage is sewed, must present always upward and opposite to the direction in which the pressure is to be exerted—i. e., if the outer border of the great toe on the right side is affected, the seam should be directed upwards and towards the left side of the patient. Thus applied, the bandage will become somewhat wound around the outer side of the compress, which is to be pressed, at first, very gradually and tenderly, but somewhat forcibly, downwards and outwards, until secured in that position by several turns of the bandage around the great toe, carrying it first down, between that member and the second toe, and around several times. The great toe is then to be depressed and forced outwardly, under the second, which is placed upon the compress, and lightly bound in that position by a few turns of the bandage.

"The bandage should be re-applied, at least as often as once a week. If the prominence of flesh, against which the compress is to rest, is very irritable, a layer of lint, anointed with simple cerate, should intervene. At the first impression of the compress to the sore flesh, the patient experiences some degree of pain or soreness; but the very prompt abatement of suffering following the relief of the inflamed tissues from the irritation of the sharp nail, and also the diminished turgescence of the part, induced by the uniform pressure of the compress and bandage, will prove an ample recompense. The comfort of the patient and celerity of recovery are much enhanced by keeping the limb in an elevated position. It is a matter of surprise, bordering upon astonishment, to see the great diminution of sensitiveness in the part, at each succeeding application of the apparatus. Six or eight weeks is time sufficient for relief, generally, or for such an improvement as to render it safe to intrust the case to the care of the patient."

A much simpler plan, and one we have pursued for twenty years, and which perfectly fulfils the indication of keeping the nail apart from the irritated flesh, is to introduce by gentle pressure with the edge of a pen knife, a portion of lint between the nail and the flesh. By a little manipulation, this may be effected with little if any pain, and the process is to be daily repeated. It will be found that with each repetition of the process, the space between the nail and flesh increases, that a larger portion of lint may be introduced, and that its introduction becomes easier. We have employed this mode of treatment so often, and with such satisfaction, that we confidently urge it on the attention of the profession.

*Case of Impalement.*—Dr. A. C. GARRATT, communicated to the Suffolk District Medical Society, the following remarkable case. The subject of it was

a sailor, whose magnificent chest attracted the narrator's attention particularly on account of a very large depressed semilunar cicatrix, situated directly over the region of the heart.

"His name was John Taylor. On the 6th of May, 1831, when about twenty years old, he shipped on board the Danish brig *Ann*, of Scarborough, then lying at the London docks, getting ready for sea; on that very day, while endeavouring to direct and enter what is called the step-bolt, or iron pivot, of the trysail mast into its socket in the rail, the tackling gave way, precipitating him backward upon the deck. The mast, with the iron bar fixed in its lower end, dropped almost perpendicularly upon his chest, driving the rough iron through him into the plank beneath, while the square end of the spar fell upon his thorax, compressing it in a most frightful manner. He remained thus transfixed to the deck, with the mast upon him, until new tackling could be rigged to hoist the spar. He was taken to the London Hospital, apparently in a dying condition, but, rallying under prompt surgical treatment, he gradually recovered. At the end of twelve months, he left the hospital, soon after shipped again as a sailor, and has continued in that employment up to the present time, about twenty-six years. He said that he had not been in London for eighteen years, but that his case must be known to the surgeons there, and that the bar of iron was taken from the mast and placed in the Museum of the Royal College, together with a sketch showing the position, size and shape of his cicatrices.

"So extraordinary a history seemed to warrant investigation, and I prevailed on Mr. Taylor to accompany me to London, where Drs. Ferguson and Partridge recognized him and corroborated his statement. In the Museum I found the sketch and the bolt, and also a record of the case, from which I gained some additional facts. The scalp was extensively laid open; the inferior maxillary bone was fractured, and a portion of it, with several teeth, removed, and there was considerable exfoliation from the different wounds, during his convalescence. At the time of the accident, the anterior extremities of the fifth and sixth ribs of the left side, together with their cartilages, were removed from the wound in front, while portions of the necks of the seventh and ninth ribs of the same side, with a mass of muscle and integument, were removed from near the spine where the bolt made its exit. These are preserved as a wet preparation in the Museum of the London Hospital. The mast weighed 600 pounds, and was thirty-nine feet in length. The bolt was six inches in length. He left the hospital in good condition, and since the accident has had uniform good health, suffering from no general or local weakness, no sensation of stricture about the thorax, no pain, no cough. He lives well, but temperately. On auscultation and percussion, the organs of the chest and abdomen seemed perfectly normal; in short, he presented, in all respects, the appearance of a perfectly healthy and robust man.

"On reviewing this case, we are naturally led to inquire what circumstances could have saved the man from instant death. Was it simply from the fact that the bolt of iron was blunt on its end, and, therefore, after penetrating the anterior parietes of the thorax, it pushed aside, without piercing the heart, blood-vessels, and other important organs, and came out through the back without having caused a necessarily fatal wound? It is instructive, because it is recorded that the man had prompt and thorough surgical treatment, as if he were expected to recover. It also reminds the profession of what the '*vis medicatrix nature*' can, and sometimes will do, if aided by skilful hands."—*Boston Med. and Surg. Journ.*, Jan. 14, 1858.

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*Extraction of a Living Child, by Turning, after the Death of the Mother.*—Dr. G. W. THORNTON records (*Cincinnati Lancet and Observer*, Feb. 1858), an interesting case of this. The mother died suddenly whilst in labour, from some unascertained cause. Forty minutes elapsed after the last expiration of the mother before Dr. T. arrived, and was able to attend to the undelivered child. He found that the membranes had been ruptured, that the head was in the cavity of the pelvis, the vertex presenting at the inferior strait. Dr. T. raised the fetal head, passed a hand into the flaccid womb, turned the child and extracted it as far as the head without delay; at this point it momentarily hung

until assisted by the fingers in its mouth. Thus, forty-five minutes elapsed from the last expiration of the mother to the complete extraction of the child.

The child did not breathe, and was of a bluish colour; but a slight tickling sensation could be heard on the ear being placed over the heart. The fauces were cleared, Marshall Hall's ready method then diligently practised for half an hour, when a convulsive inspiration took place. This method was persevered in, assisted by aspersions and frictions, and at length respiration was established. The child, a boy of the average size, sucked vigorously at the bottle, and lived for three weeks and two days; its death, probably, resulting from want of sufficient care.

*Absence of Urea and Uric Acid in Urinary Secretions in Yellow Fever.*—Dr. F. PÉYRE POUCHER states (*Charleston Medical Journal and Review*, Jan. 1858), that after careful microscopic and other examinations of the secretions from the kidneys, during the whole course of an epidemic of yellow fever, occurring in Charleston, in 1856, he has been able to trace the constant absence of uric acid and urea. This failure of the urinary organs to eliminate this substance Dr. P. regards as of great importance, and he attributes to it some of the most dangerous symptoms in the progress of the disease, as the coma and other indications of torpor of the brain in the latter stages.

*Creasote in Dysentery.*—Dr. G. E. ELMER states (*New Orleans Med. News and Hospital Gaz.*, Jan. 1858), that in an epidemic dysentery of a very malignant and fatal type, which prevailed twelve years since in a malarious section of the Parish Avoyelles, and which resisted ordinary treatment, creasote in doses of two drops in gum Arabic mucilage, given every two hours, arrested the disease.

*Euphrasia Officinalis as a Cure for Epilepsy.*—Dr. J. G. KYLE recommends (*Western Lancet*, Dec. 1857) the *Euphrasia Officinalis* as a remedy for epilepsy. His attention was directed to it, from its being used as a domestic remedy for the cure of the disease, and he has employed it himself with success. He gave four ounces of the infusion every morning fasting.

*Treatment of Prolapse of the Funis.*—Dr. T. GAILLARD THOMAS, in a paper recently read before the New York Academy of Medicine (*New York Journ. Med.*, March, 1858), recommends that in cases of prolapsus of the funis, the woman should be placed on her knees, with her face and chest resting upon the bed. His rules for the treatment of prolapsus are:—

1st. If the cord is detected before the waters have broken, let no manual assistance be offered, but place the woman at once in position, and trust to this for its return to the uterus.

2d. Should the waters have flowed away, and left the cord below the head, place the woman in position, and push it up with the hand if practicable, or with a porte cordon, consisting of a gum elastic catheter, with a tape passed through it, if not so—

3d. Let no manipulations be commenced until the woman be placed in position.

*Inoculation with Gonorrhoeal Matter for the Cure of Granular Lids and Corneitis.*—A case is recorded in a recent No. of the *Cincinnati Lancet and Observer* (Jan. 1858), of granulations of the lids with corneitis, treated by the application of gonorrhoeal matter to the conjunctiva. We regret to find that such a practice has been introduced in this country, for though sanctioned by Piringer and Jaeger, we believe that it is wholly unnecessary, exceedingly unsafe, and, in fact, calculated rather to aggravate the mischief than afford relief. We had hoped that such eccentricities and extravagancies in ophthalmic practice would find no imitators among ophthalmic surgeons in this country.